Appeals Process

• What Should I Do If I Have A Claim Denied Or Experience A Problem That I Am Unable To Resolve With My Health Plan?

The State Health Benefits Program has a specific appeals procedure for employees and retiree group members (including long term disability participants) in the self-funded plans (including the COVA Care Plans, Advantage 65, Option I and Option II) or in the regional plan (Kaiser Permanente) who experience final, adverse decisions from their health plan. For example, if a participant's medical claim is denied, the participant may appeal the denial to his/her health plan. If the plan issues an unfavorable final decision, then the participant may appeal to either the Director of the Department of Human Resource Management (for those in the self-funded plans) or the State Corporation Commission (for those in the regional plan). The appeals process does not, however, adjudicate claim denials by Medicare.

• What Is The Process For Filing An Appeal?

For Self-Funded Plan Members:

You must exhaust all appeals regarding claims through your health plan before appealing to the Director of the Department of Human Resource Management (DHRM), and you must file the appeal in writing within 60 days of the final, adverse decision by your health plan. Appeals on non-claim matters, such as eligibility or policy, go to the Director of DHRM without going through the plan appeals process.

In the appeals process, the Director of DHRM will offer an informal fact-finding consultation. A decision will be rendered within 90 days of the submission of final information pertaining to the appeal. If the claim remains denied, specific written reasons will be given, including specific references to law, regulation, contract provisions or relevant policies which formed the basis for the denial. Also, at this level, the employee or retiree group member will be notified that, if desired, he or she may exercise the appeals process under the Administrative Process Act (APA).

For Regional Plan Members:

If you are enrolled in the Kaiser Permanente regional plan, you may appeal claims decisions to the State Corporation Commission (SCC) after you have exhausted internal appeals with your health plan. For more information, you may call (804) 371-9032 in Richmond or toll-free at (877) 310-6560, or access the SCC web site at www.state.va.us/scc. Only appeals on eligibility or policy may be sent to the Director of DHRM.

• What Is An External Review?

External review of denied claims is a review by independent clinicians. It works like this:

Self-Funded Plans:

When your medical claim appeal is submitted to DHRM, the denial of coverage will also be reviewed by an impartial external review organization. It will be the responsibility of the external review organization to confidentially examine the final denial of claims to determine whether the decision of the plan is objective, clinically valid and compatible with established principles of health care.

Once the external review organization has made a decision, it must provide written notification to DHRM. The outcome of the independent review may be either to overturn or uphold the denial.

Regional Health Plan:

Once internal medical plan appeals are exhausted, members of the Kaiser Permanente regional plan may file a request with the State Corporation Commission's Bureau of Insurance for an external review of the denied services. All appeals must be filed within 30 days of the final decision of the insurance plan to deny coverage.

If the appeal meets the criteria, an independent health care review organization, not affiliated with the member's health plan, will be asked to conduct a review of the appeal.

A written recommendation will be made to the Commissioner of Insurance, who will issue a written ruling. The ruling is binding, with no opportunity for appeal.